

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/02/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>MARYSVILLE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1617 RAMIREZ STREET, MARYSVILLE, CA 95901 YUBA COUNTY</b>		
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health: [REDACTED], HFEN</p> <p>CLASS AA CITATION -- PATIENT CARE 23-2019-0004705-F Complaint(s): CA00115350</p> <p>F 323 483.25(h)(1) ACCIDENTS</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>The facility failed to ensure that Resident 1's immediate environment remained free from accident hazards by not putting down the resident's side rails when the resident was not being turned. The facility failed to ensure that Resident 1 was safe from accidents by not using a bed alarm that would have notified staff that Resident 1 was getting out of bed. Resident 1 was found with her head stuck between the bed rail and the bed, her chin was resting on the lower portion of the bed rail and her feet were on the floor. Resident 1, who was totally dependent for all activities of daily living, choked to death on the side rail while she was unable to free herself from the side rail.</p> <p>Resident 1 was an 84 year old female admitted to the facility on 10/25/05, with diagnoses which included osteoarthritis, psychosis, and Alzheimer's disease.</p>				

Event ID:L4LZ11

4/24/2008

11:07:15AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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	<p><b>Continued From page 1</b></p> <p>Review of Resident 1's Minimum Data Set (MDS), a standardized assessment tool, dated 4/11/07, revealed that Resident 1 had severely impaired decision making abilities along with short term and long term memory problems. She was assessed as being totally dependent upon staff for activities of daily living such as hygiene, bathing, and dressing.</p> <p>Resident 1 was totally dependent upon staff for mobility in bed, and transfers to and from the bed. The MDS listed that the resident was lifted manually or mechanically in and out of bed and/or a wheel chair.</p> <p>Resident 1's care plan with an original date of 10/28/05, addressed the resident's potential for falls and injury due to her poor safety awareness related to her confusion. The plan identified the use of 1/2 bed rails (rails positioned at the top half of a bed, so that a person could get out of the lower half of the bed), and alarms (something that would sound off if detached by movement) while Resident 1 was in her bed, in a chair or in her wheel chair.</p> <p>Review of the resident assessment protocol report (RAP) dated 4/12/07 revealed that Resident 1 had not attempted to get out of bed or wheel chair and had not fallen in the last 6 months. Under pressure ulcers of the RAP it was documented that the resident was at risk secondly to a decrease in mobility.</p> <p>A review of Resident 1's re-admission physician's orders dated 4/24/06 revealed an order for "1/2 rails up for positioning and mobility."</p>				

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	<p><b>Continued From page 2</b></p> <p>Resident 1's care plan dated 4/12/07, related to her diagnosis of dementia identified that the resident was at risk for potential injury related to inappropriate judgment. The goal was that the resident was not to have any injuries. One listed approach was to turn and reposition her every 2 hours.</p> <p>Resident 1 had a care plan, dated 4/12/07, which addressed the resident's inability to care for herself. The care plan identified that 1/2 side rails would be used for positioning and mobility.</p> <p>Resident 1's care plan which addressed her medical diagnosis of osteoporosis (weak bones) listed the use of a Sara lift for transfers, a low bed, and 1/2 side rails for positioning and mobility.</p> <p>According to medical professional studies, the potential for serious injury is more likely from a fall from a bed with side rails than from a bed where the side rails are not used.(Miles, Irvine, P. Deaths caused by physical restraints. Gerontologist 1992;32(6):762-6 and Parker K, Miles SH. Deaths caused by bed rails. J Am Geriatr Soc 1997;45(7):797-802)</p> <p>Review of Resident 1's nurses notes dated 5/21/07, at 4:15 am revealed Resident 1 had been found laying on the floor of her room, her head was caught between the half rail and the bed. RN 1 documented that Patient 1 was non responsive, without a pulse or respirations, and both hands and thighs were cool and cyanotic (bluish in color). RN</p>				

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	<p><b>Continued From page 3</b></p> <p>1 documented that the resident had last been observed asleep at 3 am.</p> <p>On 6/20/07 at 1 pm, an administrative nurse (RN 2) was asked if a bed alarm was in use on 5/21/07, as described in Resident 1's care plan for the prevention of falls. RN 2 stated that the bed alarm was not used, as Resident 1 had never tried to climb out of bed since her admission.</p> <p>During a telephone interview on 6/21/07 at 7:45 am, RN 1 stated that she worked at the facility the night when Resident 1 expired. She recalled the incident on 5/21/07 at 4:15 am with "the one who fell out of bed and choked." RN 1 stated that on the morning of 5/21/07, she was entering Resident 1's room to see her roommate, then observed Resident 1 on the floor. RN 1 stated the last time she saw Resident 1 was when she did rounds about midnight. RN 1 stated she checked with Resident 1's CNA's and that they informed her that they repositioned her around 3:15 am. RN 1 stated that Resident 1 normally slept all night, and that she had never tried to climb out of bed.</p> <p>On 6/21/07 at 2:45 pm, during a telephone interview, CNA 1 stated that Resident 1 was sleeping when she did rounds at 11 pm on 5/20/07. CNA 1 stated the last time she checked Resident 1 was at 2 am, and that the charge nurse called her around 3:15 am because she found Resident 1 on the floor. CNA 1 stated that she didn't need help with turning Resident 1, because Resident 1 would help by grabbing the side rail.</p>				

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	<p><b>Continued From page 4</b></p> <p>On 9/26/07 at 1:45 pm, Resident 1's husband stated that he had asked for full side rails but the head nurse stated that they could not use full side rails because people were getting hurt. Resident 1's husband was asked why she had the half rails and he stated, "I guess so she wouldn't fall out of bed."</p> <p>On 9/27/07 at 1:15 pm, during a telephone interview, Resident 1's daughter was asked why her mother had a side rail. Resident 1's daughter stated that her mother had no mobility, and referring to the use of the side rail for mobility purposes, stated that Resident 1 "could not do anything with it."</p> <p>On 10/23/07 at 9:48 am, during a telephone interview, CNA 3 stated that she had provided care for Resident 1 on the day shift for approximately 8 months. CNA 3 stated that Resident 1 was dependant on staff for all of her care including transfers, and personal care. CNA 3 stated that Resident 1 sometimes would turn in bed when asked to, or with minimum assistance and would grab the side rail with both hands, one above the other. CNA 3 stated that on two occasions she could recall walking past Resident 1's room and had observed Resident 1 sitting on the floor on a mat that had been placed on the floor below her bed.</p> <p>Another interview with CNA 3 was conducted on 11/2/07, along with a written declaration. CNA 3 documented that Resident 1 "was known to roll out of bed." This declaration directly contradicted the</p>				

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	<p><b>Continued From page 5</b></p> <p>information in the RAP dated 4/12/07, which revealed that Resident 1 had not attempted to get out of bed or wheel chair and had not fallen in the last 6 months.</p> <p>Another interview and declaration was conducted with RN 2 on 11/2/07 at 1:55 pm. RN 2 documented in her declaration that Resident 1 had a history of attempts to climb over the bed rails. RN 2 went on to further document that she had informed Resident 1's spouse that there had been cases of people being injured from side rails.</p> <p>A review of the Coroner's Report and final autopsy report was conducted on 9/27/07. The Coroner's report revealed that a sheriff observed Resident 1's body lying partially on the floor, her head appeared to be stuck between the bed rail and the bed. Her chin was resting on the lower portion of the bed rail. Resident 1's autopsy report listed the cause of death as asphyxia (insufficient intake of oxygen), due to compression of the larynx and a fractured larynx.</p> <p>On 9/26/07 at 1:45 pm, Resident 1's husband stated that he had asked for full side rails but the head nurse stated that they could not use full side rails because people were getting hurt.</p> <p>The facility failed to ensure that Resident 1 was safe from accidents by not using a bed alarm that would have notified staff that Resident 1 was getting out of bed. The facility failed to clarify if the resident could or would slip out of bed. Although the facility placed a mat on the floor next to Resident 1's bed,</p>				

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	<p><b>Continued From page 6</b></p> <p>the facility failed to ensure that Resident 1's immediate environment remained free from accident hazards by ensuring that Resident 1's side rails were not present when the resident was not being turned. Resident 1 was found with her chin stuck on the inside of the side rail on her bed. Resident 1 choked to death on this side rail.</p> <p>These violations presented either (1) imminent danger that death or serious harm to the patient or resident of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patient or resident of the long-term health care facility would result therefrom and were a direct proximate cause of death of the patient.</p>				

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